

LIVE THERAPEUTIC MUSIC DATA COLLECTION FORM

Session Date: _____ **Time:** _____ **Patient ID:** _____

Age (check ONE): under 18 over 18 **Gender (check ONE):** Female Male

Patient Location (check ONE): Hospital Home Caregiver/Relative's Home
 Non-hospital Medical Facility (specify): _____

Medical Diagnosis (check ALL that apply):

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skeletal/Orthopedic | <input type="checkbox"/> Obstetrics |
| <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Psychiatric/Mental health |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Surgical | |

Before Music Session – Presenting Conditions:

Observed General Conditions	Check ONE column in EACH row:		
	Yes	No	Can't tell
Awake			
Confused/Disoriented			
Smiling			
Crying			
Verbally coherent			
Non-responsive			
Restless			
Agitated			
Moaning			
Furrowed brow			
Clenched hands			
Curled up/Tense position			
Other (specify):			

Observed Breathing Conditions				
Circle ONE number for each condition:				
Erratic	1	2	3	4 Steady
Shallow	1	2	3	4 Deep
Relaxed	1	2	3	4 Labored
Cheyne-Stokes present	1	2	3	4 Cheyne-Stokes absent

Complete as many of these as available:	
Measured Conditions	Measurement
Blood pressure	/
Heart rate	beats/min
Oxygen saturation	%
Respiratory rate	breaths/min
Other (specify):	

Additional Concerns affecting Music Session (check ALL that apply):

- Hearing impaired Intubated In medical isolation Language barrier
 In hospice care Interruptions during session Other (specify): _____

During Music Session – Types of Music Used (check ALL that apply):

<input type="checkbox"/> Familiar music	<input type="checkbox"/> Calming/Sedating (<50 beats/min)
<input type="checkbox"/> Unfamiliar music	<input type="checkbox"/> 50 to 70 beats/min
<input type="checkbox"/> Rhythmic music	<input type="checkbox"/> Stimulating/Upbeat (>70 beats/min)
<input type="checkbox"/> Arrhythmic music	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Improvisational music	

Length of session: _____ minutes **Instrument(s)/Voice used:** _____

After Music Session – What Changed?:

Observed General Conditions	Check ONE column in EACH row:		
	Yes	No	Can't tell
Awake			
Confused/Disoriented			
Smiling			
Crying			
Verbally coherent			
Non-responsive			
Restless			
Agitated			
Moaning			
Furrowed brow			
Clenched hands			
Curled up/Tense position			
Other (specify):			

Observed Breathing Conditions				
Circle ONE number for each condition:				
Erratic	1	2	3	4 Steady
Shallow	1	2	3	4 Deep
Relaxed	1	2	3	4 Labored
Cheyne-Stokes present	1	2	3	4 Cheyne-Stokes absent

Complete as many of these as available:	
Measured Conditions	Measurement
Blood pressure	/
Heart rate	beats/min
Oxygen saturation	%
Respiratory rate	breaths/min
Other (specify):	

Narrative Note (e.g., patient, staff, and/or caregiver comments; why you chose the music you did; patient response and CMP observations not mentioned above; comments about patient's pain before and after, if known/applicable, etc.):

Facility location (City, State): _____

Print your name and title: _____

Signature: _____ **Date:** _____

Mail completed form to: MHTP™ Central Office, P.O. Box 127, Hillsdale NY 12529